

Contents

Executive Summary	3
Acknowledgements	5
Abbreviations	5
Background Information	6
Context of the evaluation	7
Methods	7
Planning the evaluation	7
Evaluation methods	8
The Objectives of the Evaluation	9
The Project Approach	9
The Partnership Approach	9
Implementation	9
Influence	10
Moving forward.	10
Limitations to the Methods	10
Findings and Discussions	11
The Project Approach	11
The Coverage Workshops	12
On-the-job trainings and the remote support by the RECOs:	14
The SQUEAC method	15
The Partnership Approach	17
Implementation	20
Achievement of project objectives	20
Communication and dissemination of information	22
Influence and Moving Forward	23
Unintended negative consequences.....	24
Conclusions & Recommendations	25
Annexes	30
Annex 1 Documents read.....	30
Annex 2 Evaluation Matrix.....	32
Annex 3 Contacts List.....	35
Annex 4 CMN Ripple chart.....	37

Executive Summary

The Coverage Monitoring Network (CMN) was conceived by a small group of highly motivated individuals to promote a new method to measure coverage; one that could be streamlined and in part be integrated into routine M&E systems. Funding of € 1,576,919.49 was secured for an 18 month in July 2012 for a project titled 'Improving nutrition programmes through the promotion of quality coverage assessment tools, capacity building and information sharing'.

The evaluation was conducted at the end of 2013 to assess the CMN performance; to guide the future direction of the network and to check on the progress of the project objectives. The CMN has focussed on the promotion of the SQUEAC (semi-quantitative evaluation of access and coverage) method of coverage assessment and to a much lesser extent the SLEAC (Simplified LQAS evaluation of access and coverage).

The objectives of the CMN are for

- Improved capacity of selected nutrition programmes to design and implement coverage assessments and use findings to improve programme performance.
- Improved understanding of coverage assessment tools and their strategic value amongst nutrition stakeholders in selected countries
- Increased number of reliable coverage assessments carried out by nutrition programmes
- Lessons learned, best practices and technical resources are disseminated and shared at global, regional and national level.

A mixed methods approach was used in the evaluation based on qualitative methods of information gathering but supplemented by small scale survey work. This report is external and independent of the CMN and its constituent agencies: ACF, HKI, IMC, Concern Worldwide and SC.

The objectives of the evaluation as laid out in the TOR are to

1. Evaluate the implementation of the ECHO/OFDA funded project to improving nutrition programmes through the promotion of quality coverage assessment tools, capacity building and information sharing.
2. Provide solid recommendations for the future of the CMN.
3. Identify good and bad practice.
4. Evaluate the strategic positioning and added-value of the CMN for ACF

These objectives were further themed around the Project's Approach; the use of a Partnership Approach, Implementation; Influence and Moving Forward.

Overall the CMN has evaluated well, an immense amount has been achieved within the 18 month timeframe of the first phase of CMN project. The CMN has been highly active in its activities to promote the use of the SQUEAC method to measure coverage of SAM treatment and awareness raising on the importance of measuring coverage. The project model for training delivery is very good and a demand has been created within the humanitarian community for coverage assessments. It has supported 118 SQUEACs in 24 countries, covering 46 organisations mainly INGOs. The CMN has shown it can be productive and now it needs to move on to raise the quality assurance elements of its programming. The CMN has significantly raised the understanding of the SQUEAC method and is now, with its higher profile, open to increased levels of criticism.

The CMN has limited itself to the SQUEAC method of coverage assessment for the treatment of severe acute malnutrition. This is a significant limitation; CMAM programmes include the treatment of the moderately malnourished and indeed 80% of the mortality is in the moderately malnourished population.

- CMN needs to continue its work on how best to measure coverage in the moderately malnourished.
- CMN needs to ensure that the SQUEAC method is adequately validated and is as good as or better, than other coverage assessment methods.

CMN used 3 modes of training to reach agencies and raise their knowledge and experience of coverage assessments. These were inter-agency field trainings and individual agency trainings either with field support from CMN or remote support from CMN. This is an appropriate way to support agencies with different levels of skills however CMN should decide the level of support that is needed. CMN doesn't yet have a set of standardised training materials; the RECOs have not had a shared training in SQUEAC, or received any training of trainers. The RECO's time to share experiences and develop a common strategy has also been very limited.

- The CMN needs to build in quality assurance. It should gather, collate and standardise the tools and definitions used by the RECOs and develop a standardised training package.
- RECOs should meet face to face twice a year to share lessons learnt, to document new developments and build up their personal skill sets (including in training skills and technical aspects of coverage assessments).

The website is an underused resource that could be more populated with the SQUEAC tools, offer a search facility to improve its navigation and be integrated with other social media. An inter-connected social media strategy could encourage a more active use of their growing knowledge base and prove to be a useful adjunct to the CMN with its low level of field presence.

- The website is fully populated with a standardised SQUEAC toolkit, standard definitions, teaching materials and reference documents as part of an inter-connected social media strategy.

The CMN has positively increased the number of trained and experienced personnel who can implement SQUEAC coverage assessments; however an 18 month time frame is much too short to lead to any degree of sustainable capacity development. It is also too short to adequately assess any improvement in programme performance. In its second phase the CMN needs to focus on the integration of coverage assessment into the routine monitoring of programmes at the NGO and the national level. The SQUEAC method is relevant for use with SAM treatment programmes but focus is now needed on its integration into routine M&E systems at both national and INGO levels. Integration will reduce the level of effort (typically 8 people for 3 weeks), improve cost-effectiveness and support sustainability. Crucially integration will also reduce the negative impacts a SQUEAC has through lost opportunities for actual programming.

- CMN needs to put more focus on supporting the integration of SQUEAC into routine M&E systems.
- CMN needs to support the work of the service recipient agencies in making programming changes based on SQUEAC recommendations.

The 'partnership' approach to the projects management has been appropriate as the CMN grew organically; the CMN has been powered by the determination and shared belief of individuals. The project has got off the ground and served its partnership agencies well with almost no governance structures in place. However as the partnership consolidates and potentially grows it would be wise to formalise the governance systems.

- each agencies roles and duties to the network should be put in writing
- processes for decision making and communication should be formalized.
- introduce a steering committee with representatives from government, academia and the UN to consolidate CMNs position in the global arena, help broaden its outlook and define its future role and identity.

Acknowledgements

The consultant would like to thank all from the CMN and the wider nutrition community that so freely and generously gave their time to this evaluation.

The CMN core team and the ACF Evaluations, Learning and Accountability team have been impressive with their professionalism and openness which created a good working environment.

The ACF staff in Kenya were professional, hospitable and generous with their time especially as they had no direct benefit from the work.

Imelda Awino in particular needs individual praise for her support, organisation and sharing of her knowledge that made the evaluators Nairobi trip run so smoothly despite the unexpected changes in schedules and availability – many thanks.

Abbreviations

ACF	Action Contre le Faim
CA	Coverage assessment
CMAM	Community based management of acute malnutrition
CMN	Coverage Monitoring Network
HKI	Helen Keller International
IMN	International Medical Corps
MOH	Ministry of Health
OJT	On the job trainings
RECO	Regional field trainers in SQUEAC
SAM	Severe acute malnutrition
SC	Save the Children
SLEAC	Simplified LQAS evaluation of access and coverage
SQUEAC	Semi-quantitative evaluation of access and coverage
SSI	Semi-structured interview

Background Information

The purpose of this report is to evaluate the Coverage Monitoring Network (CMN) project, July 2012 - December 2013, titled 'Improving nutrition programmes through the promotion of quality coverage assessment tools, capacity building and information sharing'.

The evaluation commenced on 12th November 2013, with a meeting of Jose Luis Alvarez and Germana Comite of the CMN and Saul Guerrero and Mariagni Ellina, ELA of ACF. An inception report was produced and revised to bring it in line with the current TOR. Additional comments on the TOR were received from ECHO on 13th December. This report has been drawn up after a series of meetings, interviews and a significant amount of document review.

The Coverage Monitoring Network (CMN) is an inter-agency project implemented by ACF and its partners Save the Children, International Medical Corps, Concern Worldwide, Helen Keller International and Valid International. Working together with UNICEF and the Global Nutrition Cluster, the CMN Project was launched in July 2012 with support from the European Commission Directorate-General for Humanitarian Aid and Civil Protection (ECHO) and USAID's Office of Foreign Disaster Assistance (OFDA). Valid International was highly instrumental in the set up of the partnership, as well as in pioneering the SQUEAC and SLEAC methodologies, but is not a formal member of the partnership.

The specific objective of the CMN is to improve the capacity of selected nutrition programmes to design and implement coverage assessments and to use the findings to improve programme performance. This was to be achieved by the following activities to be undertaken between July 2012 and December 2013.

- Recruitment of appropriate technical staff – co-ordinator, administrator and RECOs
- Implement 4 one-day Coverage Workshops with nutrition stakeholders (including Ministry of Health, NGOs, UNICEF, and other nutrition cluster partners) in Kenya, Bangladesh, Burkina Faso and Nigeria.
- Implement 4 inter-agency field trainings with nutrition stakeholders (including Ministry of Health, NGOs, UNICEF, and other nutrition cluster partners) following the workshops.
- Implement 4 one-day After Action Reviews following the previous activities with the same stakeholders.
- Support agencies in the Planning and Budgeting of Coverage Assessments
- Provide On-the-Job Training (OJT) in the Design, Planning, Implementation and Analysis of Coverage Assessments (for low/medium experience programmes)
- Provide Remote Support for the Design and Planning of Coverage Assessments.
- Develop a Coverage Monitoring Network (CMN) website
- Implement Regional Lessons Learned Workshops
- Research, document and produce Policy Papers on common trends in nutrition programme performance

Context of the evaluation

This evaluation will be external and independent of the CMN, ACF, HKI, IMC, Concern Worldwide and SC. It is being undertaken towards the end of the 18 month project in order to evaluate performance of the partnership; to give consideration to the future direction of the network and to assess the progress of the CMN in line with its prescribed path. The CMN has focussed on the promotion of the SQUEAC (semi-quantitative evaluation of access and coverage) method of coverage assessment and to a much lesser extent the SLEAC (simplified LQAS evaluation of access and coverage). Primarily the SQUEAC has been used to assess coverage of SAM treatment but recently some have measured MAM coverage. One SQUEAC has measured SAM and malaria coverage.

Coverage assessments are typically complex processes within the nutrition sector and the SQUEAC had been developed to slim down the procedure and to allow for a significant amount of integration into routine monitoring systems. An initial SQUEAC takes on average 3 weeks and 8 people to implement with field work interspersed with 1-2 days of classroom based data analysis sessions. SQUEAC uses a combination of qualitative and quantitative information gathering methods and is typically run in 3 stages

1. Stage 1 Routine monitoring data is analysed to identify areas of potential high and low coverage. In depth discussions and SSIs to determine barriers and boosters to CMAM programme uptake.
2. Stage 2 Small scale survey to determine areas of high and low coverage.
3. Stage 3 Quantitative wider area survey, statistical analysis to determine coverage estimate.

The 'Semi-Quantitative Evaluation of Access and Coverage (SQUEAC)/Simplified Lot Quality Assurance Sampling Evaluation of Access and Coverage (SLEAC) Technical Reference' book is published by FANTA. It has 241 pages and is the technical reference guide for the SQUEAC method used by CMN; it is not a training manual. Whilst the older, less comprehensive 'SQUEAC & SLEAC: Low resource methods for evaluating access and coverage in selective feeding programs' by Valid International and Brixton Health is more user friendly, 57 pages, but covers only two stages. SQUEAC will take some time to be fully understood and institutionalised in agencies new to this type of assessment. The individual tools within the SQUEAC may need refinement over time adding another level of complexity to the technical skills transfer process. The transfer of technical skills is the main feature of the CMN project but it is highly ambitious to anticipate any sustainable – independent of CMN - effects within the 18 month time frame. Sustainability would require either integration of the method into routine data collection mechanisms by NGOs/significant modification of health information systems by Ministries of Health or the availability of adequate funding to cover the SQUEAC implementation costs. Pre-service and/or in-service training packages on the use of the tools are also required to enhance and maintain quality assurance.

A wide range of stakeholders have been contacted, within the time frame of this evaluation to maximise the range of perceptions, minimise any particular stakeholder bias and allow further information sharing and/or awareness raising about coverage assessment. Stakeholders of this evaluation include

CMN core staff	Donors	Technical specialists
ACF, IMC, Concern	Valid International	Brixton Health
Worldwide, SC and HKI	NGO/MOH field staff	Website,
partner agencies HQ	National government	documentation users

Methods

The evaluation will ascertain the degree to which the CMN has achieved its objectives as laid out in the project documents and the evaluation terms of reference (TOR), see Annex 5. This will be carried out using a mixed methods approach based on qualitative methods of information gathering supplemented by small scale survey work. The evaluator will adopt a formative approach to enable learning from the initial phase of the project, identify improvements and inform on the projects future direction.

Planning the evaluation

An introductory meeting was held between ACF-ELA unit, CMN and the evaluator on 12th November to discuss the modalities of the work, set travel dates and introduce the project. A further meeting, prior to travel, was held which identified key contacts in the partner agencies, the technical advisers and to review the database. The database was used to establish the participant lists at each of the 5 CMN workshops and including the inter-agency field trainings. It was decided that an e-survey would be sent to all participants of these inter-agency field trainings. These had all concluded by February 2013 which meant that enough time for reflection on training utility and for implementation of SQUEACs has passed.

Kenya was purposely selected for the field visit as it held the first CMN workshop in October 2012 and as such offered the richest qualitative information source over the course of the project. The field trip was planned to coincide with the NIWG (Nutrition Information Working Group, part of the nutrition technical forum that quality checks in country SQUEACs) however the meeting didn't take place due to a Ministry wide ban on meetings instigated in the week prior to the visit.

Figure 1 Stakeholder analysis for CMN

Stakeholder	Interests	Importance to project	Power or influence	Score
CMN	Promotion of CA, income, prestige, profile	4	4	8
Donors	Better accountability and programming	4	4	8
Nutrition community experts	Promotion of preferred techniques, career, sector contacts	3	2	5
NGO country offices/HQ	Improved programming, profile of agency, donor accountability	3	2	5
NGO/MOH field staff	Job satisfaction, CPD, workload, community relations	3	1	4
National govts	Improved programming, reduced rates malnutrition, accountability to people	2	2	4
District health workers	Increased workload, serving population, better understanding, job satisfaction	3	0	3
Community assessed	Better service provision	2	0	2

A rapid stakeholder analysis, figure 1, was conducted by the evaluator to help frame the key stakeholders within context and to consider their involvement in the evaluation. Stakeholder analysis is a three stage process that first involves the identification of CMN project stakeholders; then considers their interest in the project and finally assesses the influence and importance each

has to the project¹. This helped in the framing of the evaluation questions and drawing up of checklists.

Evaluation methods

The evaluation used a mixed methods approach using a variety of tools and a combination of qualitative and quantitative data sources. The methods used were

1. A stakeholder analysis was carried out to highlight the importance to the project and the influence of the different groups to it. This was used to frame stakeholder interests and involvement at the outset.
2. Literature and documentation review – of CMN coverage assessment reports, the website, satisfaction surveys and policy documents. In addition relevant literature from outside of the CMN was reviewed. A full list of documents consulted is in Annex 1.
3. Semi-structured (SSIs) interviews with CMN staff, training recipients and the wider nutrition community. Checklists based around the 5 themes of the evaluation were used to guide their direction and/or prompt the respondent if needed. SSIs aim to understand different perspectives and points of view from a representative sample of stakeholders while the checklists provide a degree of standardisation to the process. The themes were presented in an order relevant to the stakeholder and not all questions on each check list were directed to all; rather recipients spoke freely but on topics within the scope and interest of the evaluation. Interviews typically lasted 45-50 minutes and notes were taken on each.
4. Nairobi field visit, 4 days. Nairobi held the first CMN workshop in October 2012, offered the widest array of stakeholders and longest length of time since CMN activity.
5. Observation at
 - a. Nairobi based FSNWG (Regional food security and nutrition working group, nutrition sub-committee);
 - b. 2 day Brussels CMN learning meeting including a group discussion with all RECOs.
 - c. London October CMN meeting ‘A decade of community based management of severe acute malnutrition’ conference.
6. Informal discussions with nutrition technical experts outside of the CMN project users.
7. An e-survey to 66 recipients of ‘on the job’ training post CMN workshops was sent out in English this represented all participants with available contact details at the 5 sites. 11 emails were not delivered. 16 responses were received, an acceptable 29% response rate considering the length of time since the workshops. Responses were had from all 5 countries holding workshops. The survey was sent out and introduced to training recipients by the CMN co-ordinator.
8. A self-administered mini-survey to assess CMN partners satisfaction within the ‘partnership’.

¹ DFID Tools for Development

Information collected from all sources was synthesized by the evaluator. This involved the repeated review over time of the evaluation matrix and noting down of perceived responses to specific questions. The interview notes of respondents were reviewed to verify, or not, new themes emerging from the evaluation process. The findings and information in this report are cross-referenced/triangulated. Qualitative methods can however reveal some stakeholder perceptions that are worthy of individual comment and if this is the case it is noted in the text. The evaluation is guided by, but not restricted to, the DAC evaluation criteria.

The Objectives of the Evaluation

The objectives of the evaluation as laid out in the TOR are

1. Evaluate the implementation of the ECHO/OFDA funded project to improving nutrition programmes through the promotion of quality coverage assessment tools, capacity building and information sharing.
2. Provide solid recommendations for the future of the CMN.
3. Identify good and bad practice.
4. Evaluate the strategic positioning and added-value of the CMN for ACF

The specific evaluation questions are grouped into 5 categories which are broken down into sub-questions in the Evaluation Matrix, Annex 2. The mechanisms to explore the evaluation questions follow below.

The Project Approach

This looks at the coverage workshops, inter-agency field trainings, the on-the-job trainings (OJT) and remote support offered by the CMN. It will be achieved principally via the semi-structured interviews, informal discussions, an e-survey and review of the documentation. An interview, supported by a checklist, to assess the support approaches will be directed to recipient agencies and the RECOs.

The Partnership Approach

The partnership approach of the Coverage Monitoring Network will be explored. The evaluation will use the following definition of partnership:-

‘a partnership is an on-going , working relationship characterised by equity, transparency and mutual benefit with a strong, supportive relationship in which the partners:

Have overlapping interests and agreed objectives

Co-create projects and programmes

Share risks as well as benefits

Are mutually accountable and

Contribute resources to the partnership’

This will be investigated via the SSIs directed to the CMN network, a self-administered mini-survey by CMN and when offered up in informal discussions.

Implementation

Achievement of the objectives of the Coverage Monitoring Network in the project document will be assessed using the log frame. Communication and information dissemination will be looked at. In addition document review and key informant interviews will be used to assess the questions from the TOR.

Influence

Influence will be investigated by looking at how much coverage assessments have been integrated into programming and expert opinion on the issue of influence from the wider community. Documents will be reviewed, ideas and opinions will be synthesised and explored by the evaluator.

Moving forward.

Ideas and recommendations for moving forward will be garnered from stakeholders throughout the evaluation process and synthesised by the evaluator including ideas to improve outcomes.

Limitations to the Methods

There are a number of limitations to this evaluation. One is the lack of involvement with the government/Ministry of Health sector. Engagement had been planned in Kenya, however just before the Nairobi visit the Director General of the Ministry of Health banned all staff from trainings, meetings and conferences. This led to the cancellation of the Nutrition Information Working Group (NIWG) meeting which is chaired by MOH and of any subsequent meetings with MOH staff.

The time frame enabled one field visit and Kenya was the best choice for this as it had hosted the first workshop and therefore had had the longest length of time to expand its coverage activities. However the Government of Kenya has been highly progressive in 'coverage assessment', it is a required indicator, and has had a strong nutrition department for quite some time and arguably presents a best case scenario. A visit to another less well performing country and or a Francophone country would have been a useful complement.

e-surveys frequently can have low response rates particularly when the time interval between the training and the subsequent e-survey is long and memories have faded. This survey was in English and was sent out in the immediate run up to Christmas. It achieved a respectable response rate of 29% but this corresponds to only 16 respondents. The information gathered is valid to support other lines of enquiry of the evaluation but can't be used to give statistically significant results. There were some inconsistencies in the availability of training recipient contact details and in response rates between the sites and this may also influence the results.

Findings and Discussions

An immense amount has been achieved within the tight 18 month timeframe of the first phase of CMN project. The CMN has been highly dynamic and active in its activities to promote the use of the SQUEAC coverage assessment method and also in raising the awareness on the importance of measuring coverage of CMAM programmes. In addition to the 5 workshops two 2 day conferences have been held, in London Oct '13 and Bangkok Dec '13. Two policy papers have been produced, with a further in press, monthly CMN newsletters circulated and articles published regularly externally in the quarterly Field Exchange. The CMN website acts as a platform for the network and repository for coverage assessment reports, some technical documents and an events calendar. The CMN project has been influential in putting and keeping coverage assessments on the international nutrition sectors agenda.

A demand has been created within the humanitarian community for coverage assessments and the CMN has supported 105 in 25 countries, covering 47 organisations. This equates to a 3-fold increase in the number of coverage assessments undertaken globally during the lifespan of the project. The average point coverage figure comes out at 60%, with a median coverage of 40%. The highest point coverage was in the Meyu Muluke camps, Ethiopia at 90.5% whilst the lowest was in Matam, Senegal at 12.1% in 2013.

All of this has been achieved by a core staff of 3-4 based at ACF-London, 6 RECOs or technical field trainers/advisers and 5 part time focal points from the partnership agencies who make up the Project Management Team. Good personal relationships have been key to the success of the partnership and the CMN staff must be applauded for their hard work, determination, motivation and energy in driving the project forward. This level of activity however has not been without its challenges and many of which are not unusual within new organisational structures. A number of these challenges are discussed below where specific questions from the TOR will also be addressed.

The Project Approach

Generally there has been a good level of support for the five coverage workshops being provided by the CMN with positive feedback received from all sites. These workshops included a one-day awareness raising session, a 3 week inter-agency field training and a one-day after action review meeting.

Three models were used by the CMN for the field training/technical skills transfer each is appropriate to reach audiences of different ability.

1. Invited to inter-agency field training following an awareness raising workshop, supported by technical expertise from Valid International or Brixton Health. These introduced managerial level staff from different agencies to the SQUEAC method.
2. An agency requesting OJT with direct field support from CMN RECOs. Requests may initiate from the coverage workshop/inter-agency field training or direct from field. They are suited to agencies with little or no experience in SQUEAC who require a high level of input. The agency may use solely own staff or invite others to attend.
3. An agency requesting remote support from CMN RECOs. Requests may initiate from the coverage workshop/inter-agency field training or direct from field. They are suited for agencies

with some capacity to implement but who need technical backup and support. The agency may use solely own staff or invite others to attend.

The Coverage Workshops

Workshops have been held in Kenya Oct '12, Burkina Faso Nov '12, Democratic Republic of Congo (DRC) Jan '13 and Nepal in Feb '13 each with subsequent 3 week inter-agency field training and 'after action' review. The training and facilitation were provided by Valid International or Brixton Health.

One day workshops

The one-day workshops have had variable levels of engagement with the host government. 10 of the 32 attendants were from MOH in DRC and 19 of 40 in Burkina Faso. 10 of 55 representatives in Nepal came from the MOH but only 2 out of 34 in Kenya but there was no MOH representation in Pakistan. Government involvement is important to enhance the appropriateness and acceptability of the project to the context. Systematic tracking of attendance by different stakeholder groups was done in Nepal and could be done at other future events to record the roles and status of participants.

The one day workshops have been attended by 161 delegates² and have served to raise awareness of coverage assessments; and have promoted significant levels of activity in Kenya, Pakistan and Burkina Faso, see Table 1. Nepal, whose workshop was the last one in February 2013, has had a higher level of buy in from the MOH and currently 11 assessments are planned for 2014. CMAM is relatively new to Nepal so there is the opportunity to explore the integration of the SQUEAC data into the routine CMAM information feed to the national health information system.

Table 1 SQUEACs post coverage workshops³

Coverage workshop site	Direct OJT	Remote support	No CMN support
Kenya, October 2012	8	6	10
Burkina Faso, November 2012	5	6	-
DRC, January 2013	2	2	-
Nepal, February 2013	1	-	-
Pakistan	1	1	10

Inter-agency field trainings

The workshop inter-agency field trainings have received high praise from all respondents to the evaluation and have produced a small cadre of approximately 45 experienced SQUEAC implementers. They were also used to train and support the RECOs.

The inter-agency field trainings would benefit from more governmental representation and participation to build understanding and promote ownership. In Kenya there were no government workers whereas 2 attended in Burkina Faso and 5 in Nepal. In the current format the trainings take 3 weeks of field work and it is challenging for MOH staff to find that length of time for an activity not in their annual work plans. Attendance for the full 3 weeks was mandatory at these sessions but RECOs have reported that it is possible to slim down the trainings for the higher grades of staff so that they could attend for 2-3 days each week. The engagement of nutrition programme managers as well as MOH managers would be enhanced if a more flexible approach was taken to the training;

² Excluding Pakistan figures

³³ The CMN effect ripple chart to November 2013.

and this should be considered for future work. Furthermore INGOs could be encouraged to sponsor MOH staff to overcome potential funding issues; some Nairobi INGOs were receptive to this idea. The RECOs reported more engagement and team cohesion in trainings with MOH representation.

In the e-survey 100%, n=16, reported increased knowledge from the field training (81% with very much improved knowledge); and 39% had implemented a SQUEAC subsequently. The non-implementers were largely in co-ordination or managerial roles. 100% found the training useful but decreasing levels of confidence were found in implementing and / or analysing data from the successive stages see Table 2.

Table 2 Effectiveness of training from e-survey, n=16

Are you confident in..	Stage 1	Stage 2	Stage 3
Implementing?	87.5%	81.25%	62.5%
Analysing?	81.25%	81.25%	62.5%

The SQUEAC method gathers both qualitative and quantitative information. Whilst many stakeholders are keen to praise the qualitative aspects in stages 1 and 2, few voiced opinions on stage 3 beyond it being more ‘challenging’. The level of statistical knowledge and practice in a SQUEAC is quite high and it may not be necessary for all the team to understand the statistical process but the survey planner, usually the Nutrition Programme Manager, should. Here lies the inherent difficulty as Nutrition Programme Managers can rarely spare 3 weeks for training unless it is scheduled in advance in their annual work plan. The CMN should explore other formats for the training to increase attendance by Programme Managers and to reduce the effects of staff absence on programmes.

In Nairobi face to face interviews were held with all the agencies, and 50% of the actual participants, that received inter-agency field training following the first CMN workshop. All the feedback was highly positive.

Security concerns prevented a workshop taking place in Nigeria and it was rescheduled in DRC (this represented a move from an Anglophone to a Francophone country) whereas bureaucratic delays in Bangladesh led to the workshop moving to Nepal. An additional workshop was held in Pakistan in Feb '13. These activities demonstrate well the flexibility and determination of the CMN core team. It is very positive to see activity in Asia, which has significantly larger caseload of malnutrition than Africa. Furthermore the treatment of severe acute malnutrition is relatively new in Nepal and the opportunity is there to integrate coverage assessment from the outset. It should be noted that for work with national governments to be effective long term commitment with senior level staff is required.

After action review

One day review meetings were held after each of the four programmed inter-agency SQUEACs (i.e. not in Pakistan) and the satisfaction surveys placed on the website. Kenya and Burkina Faso undertook SWOT analysis as well.

Generally the satisfaction surveys showed a good level of appreciation for the training but comments were made for more explanation on the Bayesian statistics (and improved software), a shorter training and more on the underpinning theory. This suggests the need to tailor the training to particular stages or particular groups within the SQUEAC. Satisfaction surveys also requested that more than one trainer be on each training and that more handouts be available; both of these would enhance the quality of training.

It's been reported that some trained 'SQUEAC'ers have changed jobs but this has not been monitored so it's not known how many have been retained within the sector, though a degree of attrition is inevitable.

The 18 month timeframe has been appropriate to begin to introduce the SQUEAC method of coverage assessment into the nutrition sector. It is not however a realistic timeframe for any degree of capacity building or building of institutional memory. The coverage workshops have been very effective and were implemented in a timely manner. They have had a direct role in the achievement of the CMN objectives. The topic of 'coverage' is relevant and appropriate to the context of nutrition programming. However without the subsequent RECO support many agencies wouldn't have been able to implement coverage assessments.

On-the-job trainings and the remote support by the RECOs:

The RECOs were the core implementing mechanism of the CMN project and 76 assessments were undertaken with direct OJT and 29 with remote support by November 2013. There has been a good spread of coverage activities that cover both Anglophone and Francophone countries as well as a significant level of activity in Asia. Attendance on the trainings has not been disaggregated by sex but the RECOs agree that more men than women have been trained and the implications of this, if any, need to be considered.

The recruitment of RECOs was done by the individual partner agencies according to their own policies, procedures and time frames. The RECOs joined over 3-4 months and there was not a shared common training or orientation prior to deployment. They did however start with different levels of experience both in the SQUEAC method and in training techniques. The RECOs each attended one of the inter-agency field training workshops implemented by Valid International to build and or consolidate their knowledge in coverage assessments. The different workshops also provided the tools and teaching materials to the RECOs. Discussion with the RECOs revealed the use of different tools and varied understandings of definitions of barriers and boosters.

A standardized, orientation and/or training for the RECOs in coverage assessment methods and training techniques is needed to build elements of quality assurance into the project. It would serve to standardize the tools used, build common definitions and understandings of the tools and to build a stronger community of practice. A standardized toolkit is required. It may be understandable why things haven't been written down in the midst of such high levels of activity but it is time to take stock address these issues.

The OJT format doesn't allow for any follow up post-training to provide support in the implementation of recommendations. As such the CMN doesn't know if their recommendations are acted upon nor do they learn about what does and doesn't work in particular environments.

There have been some concerns among stakeholders over the operating standards of the CMN and if the CMN wishes to maintain its credibility these must be addressed. Individual comments were received from different stakeholder groups and included

'it was unclear why some people were attending the training'

'they come in as outsiders with a vertical approach... no integration no sustainability.. . '

'they have little time to follow up with agencies'

'reports are good quality but how much is new knowledge and how much cut and pasted'

'recommendations are good but what does an agency *do* with it?'

‘fears over the quality of one training’

‘they had much technical knowledge but not a trainer .. didn’t engage ’

However the CMN operates in the global arena and as such needs to be sensitive to multi-cultural issues both within and without its network. Attitudes to both participatory training methods and learning by rote/lecture style vary considerably globally and different RECOs have different styles and different skills to offer. CMN should however work to harmonize the chosen methods across the RECOs and to enable learning between RECOs.

- CMN needs standard training materials
- Definitions of its categories of barriers and boosters
- A common approach to techniques and understanding of the SQUEAC tools
- RECOs require an understanding of the range of different coverage assessment methods in order to discuss the suitability of the SQUEAC method in relation to the others.

Naturally there has been an inherent variation in the quality of coverage assessments that are being undertaken as this is shaped not only by the RECO but by the existing capabilities of agencies and the engagement & support of Nutrition Programme Managers and Country Directors. The remit of the CMN is to build capacity and in order to learn the recipient agency needs to take on a level of responsibility that stretches them. Variations could also be due to RECOs taking on increased writing responsibilities with weaker agencies.

No evidence was found to suggest that OJT or remote support was more effective at building capacity. It is the requesting agency that determines the level of support that they need and this decision may be influenced by the cost of the exercise. The key determinant here should be the current level of capability of the agency to undertake the exercise. Whilst the CMN offers free access to technical expertise, agencies may choose to use a low risk option with maximum CMN support but with a lower level of ownership or conversely a free service allows less financially secure agencies access to an otherwise unobtainable service. In order to maximise cost-effectiveness it would be prudent for the CMN to assess each request to determine the level of need for RECO support.

The RECOs reported that the use of mixed teams was very beneficial to the OJTs leading to greater cohesion of the team, the sharing of different knowledge and experiences. The presence of MOH staff within teams was appreciated by the RECOs and could be made a requirement for service provision.

In Kenya, coverage assessments are routinely discussed in the relevant co-ordination fora and are subject to a rigorous quality assurance process from the NIWG. Reports from stage 1 and 2 are reviewed in inter-sectoral meetings and require permission before proceeding to stage 3. In 2012 the Nutrition Unit of the Ministry of Health adopted the use of SQUEAC for coverage assessment and all CMAM programmes now need to plan and budget for them in their proposals. Prior to 2012 SMART surveys were used to give a proxy indicator of coverage. This is a model for best practice.

The SQUEAC method

The CMN has focussed almost exclusively on the SQUEAC method and this increases the networks vulnerability to criticism. Whilst the SQUEAC has proved to be excellent at bringing people together to talk meaningfully about programming issues it also has its detractors. The method is relatively new and evolving; it has not been formally peer reviewed and challenges to it can easily be made.

Issues with the SQUEAC method were easily uncovered during the evaluation process from within and outside of the CMN.

1. The SQUEAC uses ranking to quantify the importance and relevance of barriers to treatment and this brings in a subjective judgement. A variety of stakeholders mentioned that they disagreed with judgements made on SQUEACs that influence result.
2. A stage 3 questionnaire used to determine barriers to uptake of CMAM services starts by asking the primary carer, of a SAM child is not in a CMAM programme, if she knows if her child is malnourished. If the response is 'no' then the questionnaire is stopped with the assumption of 'lack of awareness of malnutrition'. There are a number of other credible reasons for a negative response including not wishing to appear as a 'bad mother' or not wishing to be impolite by saying the service is poor or the stigma of having a malnourished child. Stopping the questioning after the first question or first 'incorrect' answer changes the denominator for all subsequent questions and significantly increasing the bias to the first 'incorrect' response.
3. The conclusion of 'lack of awareness of malnutrition' can't be drawn from the question 'do you know if your child is malnourished' if the result is based on whether the child's MUAC is less than 11.5 cm.

These queries arose quickly and without answers open up the whole method to criticism. Whilst it is beyond the scope of this evaluation to thoroughly investigate the method it is clear that a range of stakeholders from different constituencies are not satisfied with it and that it requires some type of validation and endorsement.

The SQUEAC now has a higher profile so it is time to review the methods. It should be noted that different stakeholder groups have established firm technical opinions on different types of coverage assessment methodologies and as such it is important that an independent agent who is not familiar with CMN or Valid International or FANTA be used to oversee any peer review and/or validation. It is important that the bar for the validity of the method is not set higher than for other methods in use.

Typically, this evaluation found, that SQUEACs are implemented as a 3 week exercise using teams of around 8 people to implement. This level of effort needs to be justified for the collection of a single indicator for a single programme and this can be done if it can be shown to lead to significant future improvement of coverage. A range of stakeholders also reported SQUEACs being implemented at the end of a programme as an evaluation tool.

It is important to ensure that only the relevant stages of the SQUEAC are used; that adequate programming time is available to improve coverage and to integrate tools as far as possible into the routine health information systems. In some ways the CMN have become a victim of their own success in that they have raised the profile of coverage assessments and now they have the responsibility to defend the method and to show that it contributes to maintaining/raising standards to acceptable levels.

Now that the CMN has proved its productivity it is appropriate to shift its focus firmly onto quality assurance of its services. This will require putting into place some processes so that they can reliably produce good results and move the internal agenda onto increasing coverage rates.

The Partnership Approach⁴

The idea of the CMN was conceived initially by a small group of highly motivated individual who saw an opportunity in the policy arena to introduce a new method to measure coverage; one that would be streamlined and in part be integrated into routine M&E systems. Funding was then secured from ‘emergency’ donors, in July 2012, for a combined total of € 1,576,919.49 for 18 months. The CMN was set up in the subsequent months with the specific aim of increasing capacity to measure coverage and improve programme performance.

The CMN fits well the definition of a partnership as

‘an on-going, working relationship characterised by equity, transparency and mutual benefit with a strong, supportive relationship in which the partners:

- Have overlapping interests and agreed objectives
- Co-create projects and programmes
- Share risks as well as benefits
- Are mutually accountable and
- Contribute resources to the partnership’

The CMN isn’t a legal entity but a network of agencies with the lead agency, ACF, being accountable for the fiscal oversight of the project and taking the risk of any financial malpractice .i.e. the accountability for the public funds. It is clear that ACF, as the lead agency, has gained significantly from the CMN project in both financial and reputational terms. It is also apparent that ACF has also taken on the bulk of the responsibility and the arguably the workload. It appears that there is an implicit acknowledgement and acceptance within the CMN of this and the CMN has functioned very well with this arrangement.

The CMN has a significant lack of formal systems and governance procedures and this has enabled a fast, flexible and responsive culture that will have gone a long way to maintaining its productivity. The procedures that are in place principally support administrative and financial obligations, otherwise emailing or skypeing have been the primary modes of communication.

The CMN has been highly efficient and now, nearing project completion has a loose structure characterized by strong relationships and ad hoc co-ordination mechanisms. This is typical of the entrepreneurial and collective days of new partnerships (Fig 1). The CMN is now at a reviewing stage of its partnership cycle. There is little difference between the goals of the partnership and of its members who were involved in its set up and this supports the relative harmony of the group.

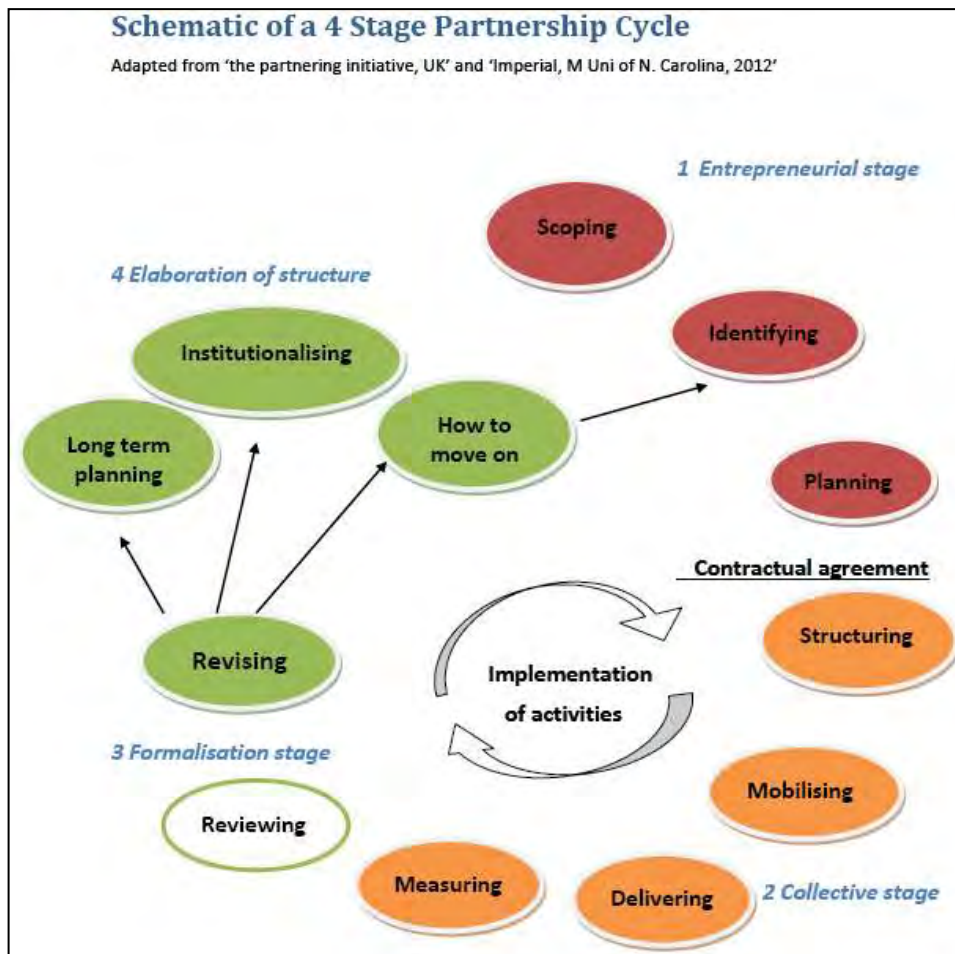
The partnership approach has been relevant and an effective approach for the network activities.

To date the CMN partner agencies have had similar responsibilities with each one employing a RECO and contributing on an ad hoc basis. If the 2nd phase proceeds with 3 RECOs there is automatically an imbalance between the partners as some lose their direct link to the field but have a free up on managerial responsibility time. The bringing in of new partners opens up the possibility of sharing tasks thematically – one agency managing RECOs, another providing technical guidance or advocacy etc. However a key finding of the evaluation process is the importance of defining the respective roles and responsibilities of existing and new members. A variety of stakeholders have expressed their belief that some agencies are trying to ‘jump on the bandwagon’ to gain access to free services;

⁴ The Partnering Initiative provides excellent guidance in this area. www.partneringinitiative.org

and that there is a need now for clearer roles and responsibilities and that more formality is required.

Figure 2



Currently the focus of the CMN is very much inward with limited external co-ordination with other nutrition fora - again this is typical during a turbulent period of development. A variety of stakeholders reported the need for the CMN to look outwards to the wider community, to assess its specific identity and its role in order to minimize duplication of efforts, boost clarity of purpose and support external relationships. The CMAM forum was mentioned but also includes SUN, GINA and the GNC. Collaboration with high impact nutrition intervention theme groups might also prove useful. (CALP, IYCF). In addition CMN is perceived to be ACF in some quarters. CMN is also perceived as a humanitarian group with vertical funding/activities that are inappropriate in developmental contexts.

The Brussels meeting, 16-17th December represented a good opportunity to meet the 'partnership' network as a group. In addition the Valid International employee who acts as the CMN focal point attended. At the meeting the principles of partnering were introduced and followed by a self assessment mini-survey on the 'partnership' to measure their satisfaction with it. All the CMN members, n=14, did the mini-survey on the partnership. The formative questionnaire, figure 3, was a self-assessment form designed to assess satisfaction and to highlight potential future areas of concern in the group and not to provide definitive answers. The question responses were measured on a Likert scale of 'strongly disagree' to 'strongly agree', with a score of 1 to 5.

The results show good general levels of satisfaction with the partnership with the lowest score being 3. The results were ranked and are presented graphically below, in figure 4.

The mini-survey suggests that

- There is currently a good level of satisfaction among the CMN partner agencies,
- With high levels of respect between partners,
- a flexible approach to work and
- an accessible point of contact within the CMN.

The points of relative concern amongst the partnership are

- the level of clarity on the roles and responsibilities of the partners,
- the absence of clear sets of rules that specify how decisions are made
- the employment of the RECOs by partner agency not by the CMN.

The partnership has served its partner agencies well during the launch phase of the project however some agencies are now looking for some formalisation of the partnerships systems and procedures. The positive and negative outcomes from the partnership were also gathered via the partnership mini-survey. These have been collated by theme and are presented below in Table 3. Positives of working in partnership outnumbered negatives in this self-assessment exercise and 2 of the 15 respondents didn't complete this section.

Table 3 Working in partnership experience

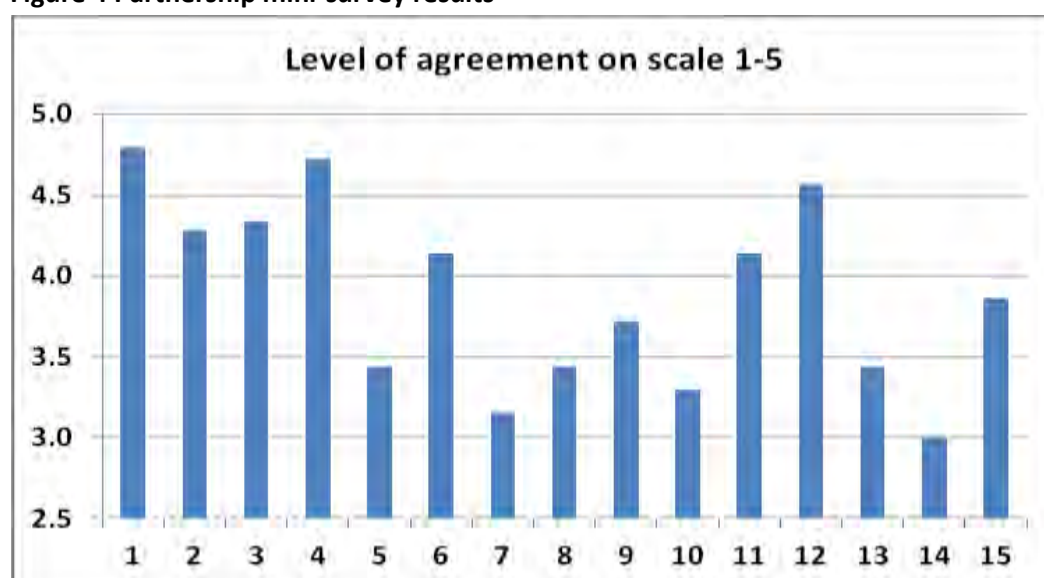
Positive outcomes	Mark *	Negative outcomes	Mark
Sharing of experiences and learning from each other.	7	Time consuming – this includes administration duties, reporting and decision making	5
Perceived efficiency of resources including sharing the workshops, technical inputs, data compilation.	6	Lack of clarity - this includes poorly defined roles, over the level of technical backstopping provided by CMN and of who RECOs represent at the country level CMN or the recruiting agency.	4
Gaining influence within the sector.	5	Potential for shallowness - issues may not be explored adequately and ACF is left to undertake most tasks.	3
Sharing of RECOs which improved ability to meet deadlines.	2	Lowering of control both financial and managerial	2
Coverage has moved up the agenda	2		
Good working environment with like minded people	2		

*The mark represents the number of respondents not significance of the issue.

Figure 3 Mini-survey questions

1	The CMN respects its partners and is receptive to their views
2	Individual partner agencies do not seek to dominate the decision-making process
3	Non partner agencies do not seek to dominate the decision-making process
4	The main contact point within CMN is clearly identified and accessible
5	The roles, duties and responsibilities of all partners are clearly understood
6	All partners communicate in an open and honest way
7	There is a clear set of rules that specifies how decisions are made
8	There are clear lines of accountability for the partners' actions and decisions
9	The partners regularly attend and play an active role in partnership meetings (virtual or otherwise)
10	It is clear what benefits each partner wishes to gain from the partnership
11	The partners shows respect for the specific needs and interests of each partner institution
12	The partners are prepared to be flexible, to discuss changing contexts to achieve common objectives
13	The partners fulfil their commitments to the partnership in a timely manner
14	Employment of the RECOs by partners, as opposed to the partnership has more pro's than con's.
15	Your MOU or project agreement has adequate detail for your agency

Figure 4 Partnership mini-survey results



Implementation

Achievement of project objectives

The project activities have been evaluated against the log frame and the CMN has performed very well, see Table 2. The specific objective of the CMN is to improve the capacity of selected nutrition programmes to design and implement coverage assessments has been achieved and can be easily verified by the number of independent SQUEACs on the ripple chart, The CMN Effect in Annex 6.

The timeframe is too short to clearly determine if the project has led to any meaningful increase in coverage. However it is hard to see with the information currently available how major advances could be made by the programme itself when many of the barriers to access are not within its scope – high opportunity costs, RUTF stock breaks, and lack of awareness of malnutrition. Coverage data

from repeat SQUEACs has only just started to come in and it is not possible to clearly assess any change. This is an area that CMN needs to follow up on in phase 2.

Table 4 Objectives from the log-frame

Result	Objectively verifiable indicators	Target	Actual
Improved capacity of selected nutrition programmes to design and implement coverage assessments and use findings to improve programme performance.	Number of trained nutrition programmes conducting coverage assessments independently	10	26
	Number of nutrition programmes supported by the project showing an increase in 10% of coverage	15	2 ⁵
Improved understanding of coverage assessment tools and their strategic value amongst nutrition stakeholders in selected countries	Number of one-day Coverage Workshops implemented	4	5
	Number of planned inter-agency field trainings conducted	4	5
	Number of planned After Action Reviews carried out	4	5
Increased number of reliable coverage assessments carried out by nutrition programmes	Number of coverage assessments carried out by nutrition programmes using appropriate methods	46	105
Lessons learned, best practices and technical resources are disseminated and shared at global, regional and national level.	Website developed	1	1
	Number of policy papers produced and shared.	2	2
	Number of people attending regional lessons learned workshop	100	176

RECOs were recruited individually and with the procedures and timelines of different agencies between August 2012 and January 2013. They are each employed/managed by one of the partner agencies but co-ordinated by the CMN and there were multiple reports that this arrangement led to significant challenges including

- Lack of clarity on who is managing the RECO; who they turn to and who they represent in the field.
- They are effectively managed by technical agency staff unfamiliar with often time consuming administrative procedures.
- Financial tracking is dependent on the procedures and timelines of 5 different agencies.

The staggered and in some cases delayed recruitment led to a large early under spend on the project expenditure.

The RECOs had different levels of experience in both SQUEAC and training (both from none to substantial), as such there is little standardisation between them. They didn't receive any joint training or orientation but attended the workshops facilitated by Valid International/Brixton Health.

The long length of time for the production of the coverage assessment reports was commented on by a variety of actors. A range of factors contributed to this

- lack of clarity over whose responsibility it is to produce the reports

⁵ Repeat SQUEACs in eight locations. 2 improved coverage, 3 falling coverage and 3 no coverage number determined but increase suggested.

- differing lengths or standards of internal procedures of the partner agencies
- different levels of experience in report writing in recipient agencies.

A face to face discussion held with the RECOs in Brussels, the second with them altogether, produced a wealth of ideas of how to improve the ownership and quality of the OJTs and the remote support. These included means to improve communications; the need to identify the roles of staff – RECO, programme managers, M&E and allow for support post SQUEAC to help with programming changes. A service delivery agreement drawn up to outline the process and signed by the CD, nutrition programme manager and RECO should include

- An assessment of recipient agency competency and the level of support needed.
- Who is needed and when during the process– M&E staff, MoH staff, nutrition programme manager etc. An agreed timeline and level of effort chart can be made.
- Outline responsibilities of different stakeholders – Country Director, Nutrition Programme Manager, RECO, CMN co-ordinator, MoH involvement, M&E staff.
- Agreement on how to produce the report, a plan of action and a follow up on agreed activities by RECO.
- To be signed by both CD and nutrition programme manager so both are known to be aware.

This process would also allow the training to be more responsive to the local context.

Communication and dissemination of information

The website provides good access to the coverage assessment reports however other features of the website are not fully populated. Few of the tools that make up the SQUEAC are uploaded and teaching and reference materials are very limited. It also has no search facility so it can be hard to find what is there. The site appears, though this is not monitored, to be used by users primarily to find coverage assessments whereas technical questions tend to be sent to the Coverage site of ENnet and/or being addressed directly to practitioners outside of the network.

The website is an underused resource and could be integrated with other social media. An interconnected social media strategy could encourage a more active use of their growing knowledge base and prove to be a useful adjunct to the CMN with its low level of field presence.

Monthly newsletters have been produced and disseminated regularly. They are well presented and have a standardised format that improves their navigation but arguably reduce the appeal of the content by making it bland. However, it appears that few people have the time to read them on a regular basis. One partner agency suggested that the newsletters be used for thematic articles and profiling agencies using the service and this could boost interest. It is suggested that the frequency of the newsletter be reconsidered and potentially reduced to quarterly or less.

Two of the three policy papers, Access for All, have been disseminated using a pebble dash approach of sending them via electronic distribution lists, personal contacts and other known fora. A third policy paper is due for publication in 2014. They are well designed and produced plus the information presented is accessible. They don't however state their target audience and the lack of a contents page suggests they are to be read cover to cover which can be off putting. Assessing readership is beyond the scope of this evaluation but it should be acknowledged that managers/decision makers may have limited time for reading them.

They are both descriptive pieces but neither of them clearly address the question in their title. The papers may prove to be a useful tool for consolidation and review of knowledge by practitioners. The first paper, released in June 2013, has had some positive feedback as a good synopsis of the state of play for treatment of SAM however it doesn't clearly explain why it doesn't address issues

relating to MAM. The use of the term 'community-based treatment of severe acute malnutrition' is confusing and easily read as CMAM and this terminology may feed into one of the reported negative consequences of the CMN - the focus of the agenda on the treatment of SAM. The second paper was released in November 2013 and not enough respondents had read the report for comment to be made. Review of the document however showed that it is focused exclusively on barriers to service uptake and no mention is made of boosters; the reasons for this are not made clear. The review document also presumes knowledge regarding the methods used in the drawing up of the barriers – SQUEAC is only mentioned in the citations at the rear of the document.

Influence and Moving Forward

There has been a significant increase in interest in the role of coverage assessments for CMAM programming over the time span of the project and this has been witnessed by the increasing demand for the CMN service. The CMN one day workshops have contributed significantly to these levels of interest. Coverage continues to be widely accepted as an important indicator of CMAM performance and the CMN has helped to raise awareness and build consensus on the best way to measure it.

Nutrition Programming

Coverage assessments are now routinely included in the partner agencies CMAM planning and costed out in CMAM project budgets. However these plans are of course dependent on continued donor support. The evaluation gauged that there is much interest from agencies to carry out or continue to carry out these assessments. In Kenya, where all coverage assessments surveys are co-ordinated and checked for quality via the Ministry of Health chaired NIWG steps are being taken to integrate the methodology into routine programme monitoring systems.

Quality assurance

Whilst there was much positive support for the inter-agency field trainings from recipients, including those responding anonymously to the e-survey, comments on the OJTs were more ambivalent, see p 14. Process is important and so it is hard to defend the CMNs general training record in the absence of rigorous methods of quality assurance. RECOs need to be trained in training methods, to be knowledgeable in comparable coverage assessment methods and have to have standardised materials. While some of this has been done it has been on an ad hoc and individual basis over the course of the project. It would be better achieved via a shared orientation and training programme. It is important that the RECOs share the same approach to the method and definitions of terms used to achieve some parity between assessments because at the current time SQUEAC means slightly different things to different people. It is important to note that at the end of the project all the RECOs are highly skilled professionals that serve the CMN well by providing the essential training.

The identification of booster and barriers to CMAM service uptake are integral to the SQUEAC process. However whilst barriers are documented in the report, executive summary and action plans boosters are only mentioned in the main report. No reason for this has yet been revealed during the evaluation.

A good start has been made on a well stylised, branded Report template. However it should be extended to include a comprehensive plan of action and a clear outline of what should be included in the methods, results, discussion and recommendations sections. A Presentation template and a Summary Results table are also available on the web site. Articles on coverage have been published in every edition of the widely read Field Exchange magazine since the CMN set up. These articles were authored by CMN partners but at times were attributed to ACF not the CMN.

Profile and Strategic Positioning

The activity levels of the CMN network has helped to establish a profile within the humanitarian community but much less so within the development sector. However there is a lack of clarity within the wider nutrition community as to its identity, some perceive it as ACF, and its mandate. A range of commentators observed that the London conference blurred the lines between CMAM and the treatment of SAM and the agenda clearly shows a 'mandate creep' into traditional areas of the CMAM forum. CMN is young and has been highly focussed on the job in hand however it may well benefit now from stronger, broader leadership to ensure closer adherence to its mandate. A broader steering group comprised of the five partner agency TAs plus other more global representatives – such as a UN, government and academic representative – would serve to consolidate CMNs position in the global arena and enhance co-ordination. The CMN may consider advocating for coverage working groups within other groups like SUN, CMAM forum.

The CMN has a good profile but to secure its strategic position in the humanitarian sector the SQUEAC method needs to be shown to be cost-effective and to show its relevance by improving coverage. Agencies, donors and MOH need to know the information that they are gathering is leading to some real change and to improvements in services. Large scale organisations and the development sector will find it difficult to adopt SQUEAC tools – and mainstream it into programme monitoring activities - without this information.

Validation

During the evaluation a range of stakeholders expressed the need for some sort of external validation of the methods and one stakeholder observed that the method is being introduced but is largely unchallenged. The SQUEAC method, or perhaps contentious tools within it, should be validated by an impartial, unknown to the main 'coverage' protagonists, academic institution. Recruitment for this should be done by placing of a tender.

Unintended negative consequences

A number of negative consequences of the CMN were reported. The increasing focus on SAM and the distortion of the meaning of CMAM was a recurring theme and one that reduces the coherence of the project with current nutrition policies. Whilst the reasons for this disconnect are understood the CMN should work towards overcoming the technical difficulties and harmonising the situation. The focus on SAM limits the role of CMN, reduces the relevance of CAs and ignores the fact that 80% of mortality from undernutrition is from the moderately malnourished.

The second negative consequence is the opportunity costs to nutrition programmes. SQUEACs have a high level of effort, at least initially, and this means that a significant level of staff is removed from everyday activities at the expense of programming. Also some feel that SQUEACs promote a survey culture and reports have come in of them being conducted at the end of a project as an evaluative not a programming tool. This is inappropriate since the principal advantage of the SQUEAC is the high level of learning about the programme and how to improve it – clearly not possible at the end of the project cycle.

Reports that the barriers (and potentially the boosters) become generic should be investigated. It was suggested that SQUEACs will not be needed if the results could be read from a generic list. CMN should also determine what programming or other changes work best to promote service uptake.

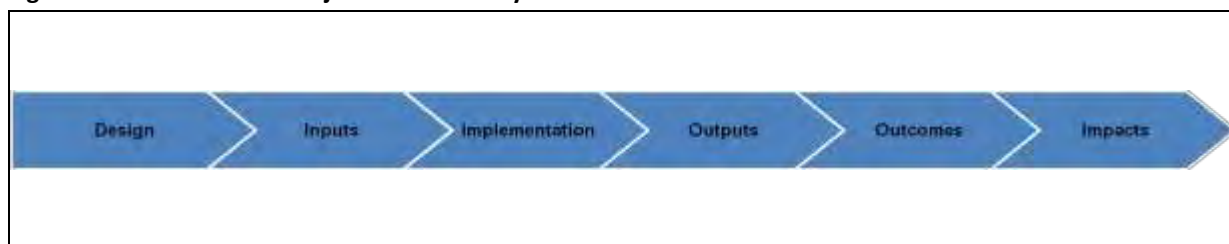
Conclusions & Recommendations

Much has been achieved by the CMN in 18 months and the CMN has been highly dynamic and active in its activities to promote the use of the SQUEAC coverage assessment method and also in raising the awareness on the importance of measuring coverage. The CMN has created a demand for coverage assessments and proved that it can be highly productive but it is now time to move on from the launch of the network into a more considered phase of review and consolidation of knowledge, whilst continuing its day to day activities. The CMN has demonstrated its added value in promoting coverage assessment methods and now needs to continue with a stronger focus on quality assurance.

It is also a time of diversification and change with the plans of expanding the network to new partners and the seeking of a second round of funding. The CMN should take some time to reflect on what they have achieved and what can be done better; they need to consider their role and identity in the global nutrition community and to address the challenges of sustainability and coherence with M&E systems.

A results chain or process analysis is represented in Figure 5 and this will be used to break up the recommendations of this report.

Figure 5 Results Chain or Project Process Analysis



1. Design of the CMN project

The idea for the CMN was conceived by highly motivated individuals who saw an opportunity to increase the access of agencies to technical expertise in coverage assessments. They then secured funding for the CMN in July 2012. Its subsequent strength is in large part due to its organic growth and both the dedication and shared objectives of its founding members. It is still personality driven, with limited governance structures, and may suffer because of this as and when founding members move on.

It is probable that the partnership will continue to develop and grow and additional governance structures need to put in place to manage this and to allow the CMN to settle into a more formal phase of its development. This will be particularly urgent as new partners come on board. Governance structures need not be burdensome and suggestions from individual stakeholders include the holding of quarterly conference calls, an agreement on decision making (how many to votes to be quorate) and the establishment of a steering committee/advisory group with representatives from for example government, SUN, academia to improve coherence.

The CMN has reacted well to many of the challenges it has faced in the past 18 months. The network has been successful and this is attractive to other agencies with several wishing to join. If the network is to increase the number of partner agencies then it is recommended that

- each agencies roles and duties to the network are put in writing
- the processes for decision making and communication are formalized.

An initial step on this process could be the introduction of regular (quarterly perhaps) virtual/conference calls for all partners and an agreement on decision making – how many to votes to be quorate.

The design of the CMN project is good and the CMN has achieved much in its short time frame. The three pronged approach to awareness raising/orientation/training has been effective at reaching both a range of individuals and agencies within the international nutrition sector. The CMN has established itself a profile and is now open to scrutiny and criticism by others.

2. Inputs

The CMN was set up to promote the use of quality coverage assessment tools and as such it cannot ignore the detractors of the SQUEAC method. Currently the CMN focus is almost entirely on SQUEAC and there is much to lose if the method, or its tools, is flawed.

- The individual SQUEAC tools need to be reviewed and validated via an independent, external and academic agency not known to CMN, CDC or FANTA. A methodological comparison on various coverage assessment methods should be undertaken to identify the comparative strengths.

The day to day running of CMN activities is co-ordinated by a small core team based in London and there is no permanent ‘field’ presence. There is no direct authority over the recipients of their training and the CMN needs to rely on good communication, co-ordination and relationships.

It is very positive, and adds value to the training operations, that the 6 RECOs are a diverse group who represent Asian and African nationalities as well as European ones. RECOs meet very rarely as a group and if brought together regularly they could share their knowledge of culture, politics and systems of learning as well as discuss technical issues and field challenges. This represents a missed opportunity for the project. The RECOs each bring with them a range of different skills and competencies that if brought together would have produced a stronger, more aligned team.

Currently there is not a standardised training package for the SQUEAC and the RECOs have different understandings and definitions of terms. This adds ambiguity to training and opens up the CMN to criticism as a training provider. Recently CMN has broadened its scope and some RECOs have used SLEAC, assessed coverage of MAM and malaria. This diversification should continue in a considered manner bringing in technical expertise as needed to support and maintain the development of CA methods. Furthermore it should train up RECOs in a range of coverage assessment methods so they can discuss their strengths and weaknesses.

- The CMN to gather, collate and standardise the tools and definitions used by the RECOs and develop a standardised training package.
- RECOs should meet face to face twice a year to share lessons learnt, to document new developments and build up their personal skill sets (including in training skills and technical aspects of coverage assessments)

3. Implementation

There has been a high level of support and appreciation of the CMN training workshops facilitated by Valid International/Brixton Health with positive feedback received from all sites. The RECOs each attended one of the CMN coverage workshops. The different levels of experience of the RECOs, recruited according to individual partner agency requirements, means that some of the first OJTs faced additional challenges. At the end of the project all the RECOs are highly skilled professionals that serve the CMN well by providing the essential training. It is important that the RECOs work continues and naïve to assume that all agencies can conduct SQUEACs following a short training without external support.

The value of the RECOs work can be enhanced with standardised inputs. The OJT and the remote support offered by the RECOs can both be effective and reach agencies with different levels of ability. Currently it is the recipient agency that determines the level of support they need and while the CMN service is free of charge agencies may simply opt for the highest level of support.

The RECOs outlined many issues relating to the implementing of the training and suggested that a Service Agreement is drawn up with recipient agencies. The purpose of the agreement is to ensure relevant personnel are aware of the training, involved in its planning and to enhance agency ownership. It is acknowledged that this process may take some additional days. RECOs agree that the trainings are most successful when the team is mixed as opposed to from a single agency; the presence of MoH staff is viewed as being particularly useful.

- It is recommended that the CMN decide with the recipient agency on the level of training support needed.
- A service delivery agreement will be drawn up to outline the process and signed by the CD, nutrition programme manager and RECO and will include
 - An assessment of recipient agency competency and their need for support.
 - Who is needed during the process and when – M&E staff, MoH staff, nutrition programme manager
 - Agreed timeline and level of effort chart. Who does what and when.
 - Outline responsibilities of different stakeholders – Country Director, Nutrition Programme Manager, RECO, CMN co-ordinator, MoH involvement, M&E staff.
 - Agreement on how to produce the report, a plan of action and a follow up on agreed activities by RECO.
 - To be signed by both CD and nutrition programme manager
- The CMN should develop more flexible training packages and continue to explore the potential for integrating SQUEAC into ongoing M&E systems.

4. Outputs

Many of the coverage assessment reports are of a high standard, with contents pages and clear information. However some are of a varying standard, lacking key features such as the Plan of Action and others have been slow to be produced. Writing the coverage assessment report is a key learning mechanism for recipient agencies; it is crucial for their institutional memory, and recipient agencies need to be encouraged to take on as much of this as is possible. However this can slow down production and lower quality in some instances. Capacity building is a long process with more time and more input being needed when starting from a low baseline.

- A detailed report format should be agreed upon and put up on the CMN website. It should be flexible to suit different agency/donor requirements and it may be helpful to include non-negotiable elements e.g. agreed plan of action based on the CMN recommendations.

The website is currently under populated with SQUEAC tools, teaching and reference materials. It is also an underused resource that could be more populated with the SQUEAC tools, offer a search facility to improve its navigation and be integrated with other social media. An inter-connected social media strategy could encourage a more active use of their growing knowledge base and prove to be a useful adjunct to the CMN with its low level of field presence.

- The website is fully populated with a standardised SQUEAC toolkit, standard definitions, teaching materials and reference documents.
- An inter-connected social media strategy is used to improve access and communication with the website and CMN.

The monthly newsletters do not appear to be widely read and their frequency and purpose should be reconsidered. The Access for All policy papers are well presented but their target audience isn't clear and they lack a contents page which suggests they are to be read cover to cover which can be off putting. They are both descriptive pieces but neither of them clearly address the question in their title. Furthermore the scope of the papers is limited; the first paper has a focus exclusively on treatment of SAM and not MAM. The second paper focuses solely on barriers to service uptake and boosters are not mentioned once. The reasons for this are not made clear in the papers and can lead to confusion to the new reader. The use of the term 'community-based treatment of severe acute malnutrition' is confusing and easily read as CMAM and this terminology may feed into the reported negative consequences of the CMN - the focus of the agenda on the treatment of SAM.

- Future policy papers are targeted to a clearly defined audience, have a stated objectives and a contents page for easy navigation.

5. Outcomes

The determination of the coverage level of SAM treatment programmes along with the knowledge of its positive and negative influences should enable programmers to increase coverage but the potential extent of improvement is unknown. Agencies may need support in making programme changes and CMN should seek out ways to support them in this. The CMN has demonstrated the ability to raise the number of coverage assessments undertaken but there has not been sufficient time to demonstrate programming outcomes clearly yet.

It seems that there is a high degree of commonality with the barriers/boosters to programme uptake and that while a significant amount of work has gone into the identification of barriers little consideration has been paid to boosters; which at times are the opposite of a barrier.

- CMN review all barriers, boosters and recommendations from the reports with a view to following up with programmes on the changes they have been able to make, challenges they've faced etc.
- CMN to follow up with the programmes served and to monitor any progress with CMAM programme indicators.
- Detailed, accurate costings for each stage of the SQUEAC would be a good advocacy tool for use in conjunction with known benefits. These would need to be done by a professional health economist and be in line with other similar work in the nutrition sector.

- A review of the boosters to service uptake should be undertaken following an agreement on the terms.

6. Impacts

The CMN has played a major part in the fourfold increase in the number of SQUEACs being undertaken in the past 18 months. It has raised the profile of coverage assessments and kept them on the agenda of humanitarian nutrition agencies. It has however had a much lower effect within the developmental community. Work also needs to be done to include MoH staff more.

Detractors point out that SQUEACs are already being implemented inappropriately, at the end of the project cycle, when their utility is limited to the final report. They argue that the opportunity costs to programmes are too high and that a survey culture is being promoted at the expense of programming. These criticisms can be minimised by the CMN working seriously to integrate it into routine monitoring. There is the feeling that the focus on SQUEAC has contributed to an increased focus on SAM at the expense of MAM and that the meaning of CMAM is being distorted.

A range of commentators observed that the London conference also blurred the lines between CMAM and the treatment of SAM and the agenda clearly identified a 'mandate creep' into traditional areas of the CMAM forum. The CMN should review its aims and purpose, the bringing in of outsiders to the network may give more oversight.

- It would be prudent of the CMN to work to overcome the difficulties of measuring coverage of MAM and to better integrate into the wider nutrition community, after all SAM is not restricted only to the humanitarian context.
- A strong steering committee based on the current PMT with representatives from government, academia and the UN would serve to consolidate CMNs position in the global arena, help broaden its outlook and help define its future role.

7. Sustainability of Programme

The CMN has made a serious contribution to build the capacity of nutrition programmes to implement coverage assessments. However capacity building is a long process and requires institutional changes as well as technical skills transfer, in the extreme this includes whole scale review of governmental health information systems. True sustainability may come in time with integration of the SQUEAC tools into routine monitoring and MoH health information systems however CMNs role in this needs to be determined.

- The CMN should consider how committed it is to institutional capacity building and consider the need for an exit strategy.

The SQUEAC method of coverage assessment itself may be less cumbersome than other methods but it still represents a serious programme undertaking. Its level of sustainability is low without integration and dependent on the on-going availability of funding.

- CMN work to continue to support the integration of coverage assessment into M&E systems and to diversify its portfolio of coverage assessment methods.

Annexes

Annex 1 Documents read

After action review SWOT analysis, Kenya, 2012
After action review SWOT analysis, Burkina Faso, 2012
Badin , Pakistan SQUEAC assessment March 2013
Bhutta, Z et al for the Maternal and Child Undernutrition Group. Evidence based interventions for improvement of maternal and child nutrition: what can be done and at what cost? <i>The Lancet</i> , 2013; 382 :
Bryce et al for the Maternal and Child undernutrition: effective action at national level. <i>The Lancet</i> 2008.
CMN Access for All. Is community based treatment of severe acute malnutrition (SAM) at scale capable of meeting global needs. Volume 1. 2013
CMN Access for All. What factors influence access to community based treatment of severe acute malnutrition? Volume 2, 2013.
CMN and Field Partners, Memorandum of Understanding, simple version.
CMN and RECOS, Memorandum of Understanding, full version.
CMN London meeting January 16-18 th 2013 minutes
CMN Phase 11: From measuring to improving coverage
CMN2 Strategic questions from donors
Coverage Assessment Freetown, Sierra Leone. June 2013. Lovely Amin
DfID (2002) Tools for Development – A Handbook for those engaged in development activity. Version 15
Emergency Nutrition Network. Field Exchanges
Field Exchange, Issue 42
Field Exchange, May 2013, Issue 45
Field Exchange, Sept 2013, Issue 46
Guerrero and Rogers (2013) Access for All volume 1: Is community-based treatment of severe acute malnutrition (SAM) at scale capable of meeting global needs?
Imperial, M. (2012) A framework for analyzing partnerships for IWRM. A conference presentation.
Intrac (2010). Monitoring and evaluating capacity building is it really that difficult. Praxis Paper 23.
Merti district SQUEAC investigation, November 2012.
Nutrition Cluster Handbook, January 2013. A Practical Guide for country level action
Nutrition Exchange, June 2013, Issue 3
Puett et al (2013) Access for All volume 2 What factors influence access to community-based treatment of severe acute malnutrition?

Satisfaction survey report SQUEAC training, Burkina Faso
Satisfaction survey report SQUEAC training, Kenya,
Satisfaction survey report SQUEAC training, Nepal, 2013
Satisfaction survey report SQUEAC training, RDC, Fevrier 2013
The Partnering Initiative, Working Paper No. 1/2008. Current practice in the evaluation of partnerships for sustainable development. Serafin et al.
UNICEF. Evaluation of Community Management of Acute Malnutrition (CMAM). Evaluation Summary. May 2013
UNICEF. The State of Global SAM Management Coverage. 2012.
UNICEF. Global SAM Management Update, Summary of Findings. Sept 2013.
www.coverage-monitoring.org
www.nutritioncluster.net/events
www.partneringinitiative.org
www.unicef.org/nutritioncluster/index
www.validinternational.org/workshop/

Annex 2 Evaluation Matrix

Issues	Key Evaluation Questions	Sub-Questions	Indicators	Sources of Data	Data Collection Tools
The Project Approach	Evaluate the 'in the field' and 'remote' support.	Was the quality of the technical assistance good?	% of positive respondents	Informants, TAs, PAs	SSIs
		Was there an appropriate balance between field and remote support?			
		What is the quality of the CM assessment reports?	Informant opinion of approach and ideas	TAs, PAs	SSI
	Was the strategy for targeting project trainees appropriate?	What was the strategy? Who has been trained? Who has not received training?	Numbers of relevant personnel trained	TAs, PAs MOU Reports	SSI Document review
	Was the design of the project suitable for the identified needs and timeframe?	Is the time frame appropriate for capacity building?	% positive respondents	Recipient agencies TAs	SSIs Document review
The Partnership Approach	Was the partnership approach the most relevant and effective in achieving the project aims?	What approach could have had a better outcome?	% positive respondents	Informants, TAs, PAs	Likert scale questionnaire
		What are benefits of working in partnership?			
		What are the costs of working in partnership?			
	Were the governance structures conducive to an optimal implementation of project activities?	What are the governance structures? How often are meetings held? What format?	MOUs % positive respondents	MOUs Website Project documents PAs, TAs	Document review SSIs

Issues	Key Evaluation Questions	Sub-Questions	Indicators	Sources of Data	Data Collection Tools
		Are roles and responsibilities clearly defined and followed? Perceptions of partners?			
	Were there any gaps that other partners (new NGOs, private sector, academic institutions etc.) could have filled in the partnership.	What is the optimum number of partners for timely implementation?	Documented gaps/issues Technical opinion	CMN staff PAs, TAs Project documents	SSIs Meetings
Implementation	Evaluate the achievement of the project according to its objectives and activities?	What percentage of health workers have been trained? (OFDA)	As per log frame	As per log frame	Document review SSI
		Was the project implemented efficiently?	% Health workers trained	Project proposal Quarterly reports	
		Was the project implemented in a timely manner?	Budget	Website	
		Were the risks/assumptions initially identified adequately mitigated?	Numbers of staff	Informants	
	Evaluate the manner in which data and findings have been communicated and disseminated within the sector and beyond.	What methods have been used to disseminate findings? Is the profile of CMN adequate?	Variety of methods used Awareness of CMN	CMN staff Project documents Informants	SSIs
Influence	To what extent has the project influenced nutrition programming?	To what extent have coverage assessments been integrated into CMAM programmes?	Expert opinions Number or % of coverage assessments repeated	Project documents CMN Partner agency staff Donors	Document review SSIs FGD/schedule d meetings if

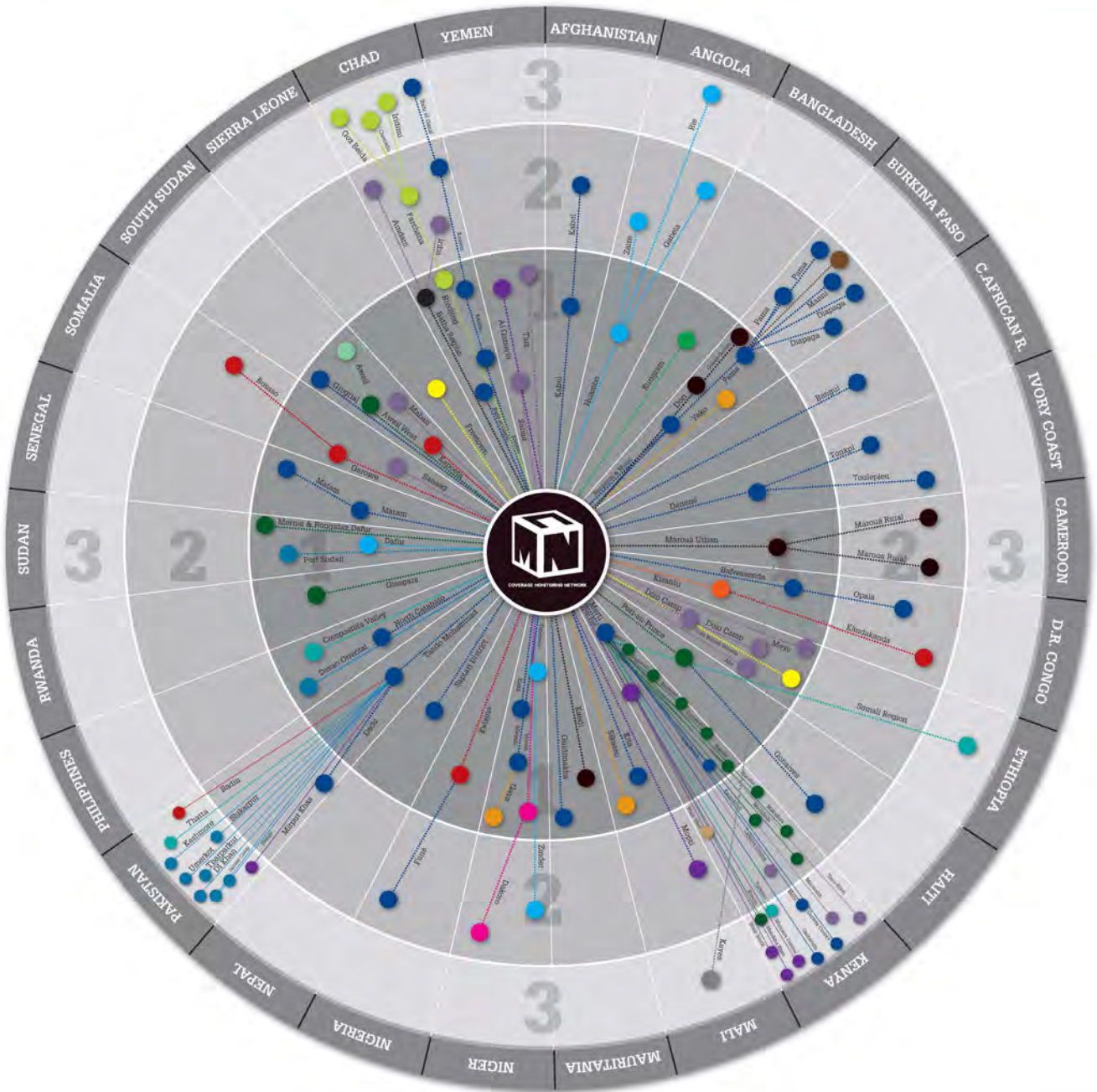
Issues	Key Evaluation Questions	Sub-Questions	Indicators	Sources of Data	Data Collection Tools
		To what extent is coverage as an indicator better integrated into the sectors definition of CMAM programming?	Number of agencies using coverage indicator in proposals. Donor requirement for coverage		possible
	Evaluate the strategic positioning and added value of the CMN in the nutrition sector	What is the alternative to the CMN? Should Valid have kept main role in dissemination of coverage? Is the CMN well positioned (does it have a good relationship with) other nutrition actors, UNCIEF, MoHs etc.	Number of recipient agencies reporting added value. Presence of CMN at strategic meetings or conferences	Recipient agency staff	SSIs Document review
Moving forward	Assess what else project could do/could have done, what kind of connections would be required to make the project outcomes work further.	What needs to be done to improve performance? What connections would improve performance?	Ideas and suggestions	Partner agency staff Expert opinion	SSIs
	What lessons does the CMN experience provide for future inter-agency collaborations and the promotion of specific tools and methods for ACF and the sector?	Is the CMN partnership network suitable for other situations – internal and external?	Lessons learnt Partner experiences Efficiency Effectiveness	Partners Project documents	
	Identify the remaining needs regarding coverage both at program and national level	What does the CMN need to work at national level?	National governments awareness of CMN National governments commitment to coverage assessments?		Discussion SSI

Annex 3 Contacts List

Semi-structured interviewee's, telephone and face to face meetings			
Jacob	Korir	ACF	Deputy Nutrition Co-ordinator, Kenya
Imelda	Awino	ACF Kenya	Nutrition Co-ordinator, Kenya
Panos	Navrozidis	ACF Kenya	Country Director
Saul	Guerrero	ACF-UK	TA
Mariana	Merelo Lobo	ACF-UK	Head of Operations
Cecile	Basquin	ACF-US	Nutrition Technical Adviser
Mark	Myatt	Brixton Health	
Amy	Mayberry	CIFF	Performance Measurement & Effectiveness Manager
Lovely	Amin	CMN	RECO
Uwimana	Sebinwa	CMN	RECO
Ines	Zuza	CMN	RECO
Sanjay	Kumar Das	CMN	RECO
Beatriz	Perez Bernabe	CMN	RECO
Melaku	Begashaw	CMN	RECO
Jose-Luis	Alvarez Moran	CMN	Core CMN staff
Sophie	Woodhead	CMN	Core CMN staff
Germana	Comite	CMN	Core CMN staff
Kate	Slee	CMN	Core CMN staff
Kate	Golden	Concern Worldwide	TA
Samuel	Kirichu	Concern Worldwide	Assistant Project Manager, Kenya
Carmel	Dolan	ENN	Director
Emily	Mates	ENN	Director
Issakha	Diop	HKI	TA
Edgar	Onyango Okoth	HKI	Nutrition Programme Officer
Douglas	Steinberg	HKI	Regional Director for West Africa
Fred	Grant	HKI	Regional Nutrition Adviser, Dakar
Andrea	Minetti	ICRC	Regional Nutrition Advisor
Caroline	Abla	IMC	TA
Caroline	Chiedo	IMC	Deputy Nutrition manager, Kenya
Mark	Murage	IMC	M&E Officer, Kenya
Kennedy	Musumba	IMC	M&E Officer, Kenya

Alexandra	Rutishauser-Perera	IMC	Regional Nutrition Adviser, Kenya
Hedwig	Deconnick	Independent	
Anne	Bush	Independent	
Eunice	Musyoki	Islamic Relief Kenya	Nutrition Adviser, Kenya
Hassan	Ahmed	Mercy USA	M&E Officer, Kenya
Hamed	Warsame	Mercy USA	M&E Officer, Kenya
Tamsin	Walters	Nutrition Works	Director
Erin	Boyd	OFDA	Nutrition Specialist
Rachel Evans	Evans	SCF-UK	TA
Emily	Keane	SCF-UK	TA
Assumpta	Ndumi	SCF-UK	Regional Nutritionist
Andrew	Hall	SCF-UK	Research, M & E - Nutrition
Caroline	Njeriti Kimere	SCUK	M&E Officer, Nutrition, Kenya
Patrick	Codjia	UNICEF	Nutrition
Mathieu	Joyeux	UNICEF, Kenya	Nutrition Specialist, Emergency
Brenda	Akwanyi	UNICEF, Kenya	Nutrition Sector Co-ordinator
Basia	Banda	Valid International	
Sergio	Regi	WFP	Food Security Analyst, Kenya
Jo	Jacobsen	WFP	Kenya
Yvonne	Forsen	WFP	Head of Nutrition, Kenya
Joyce	Owigar	WFP	Programme Officer, Nutrition, Kenya
Ester	Bousquet	xx	TA
Phone consultation			
Lucy	Gathigi Maina	Ministry of Health, Kenya	Nutrition Information working group chair

The CMN Effect



The Coverage Monitoring Network project aims to enhance the capacity of nutrition programmes to independently design, implement and analyse coverage assessments. To achieve this, the project offers varying levels of direct (on-the-job) and indirect (remote) technical support to programmes around the world. This approach, and the peer-to-peer support provided by the rapidly growing network, are responsible for the high number of assessments taking place today. This is the CMN effect.

KEY

- 1 Direct Support
- 2 Indirect Support
- 3 No Support

ACF	Save the Children	World Vision	UNHCR
GOAL	Caritas	Merlin	TDH
Malara Consortium	Red Cross	Helen Keller International	Medicus Mundi
Concern	International Medical Corps	Alima	PU-AMI
Islamic Relief	SC	Unicef	